Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: Access MediQuip, LLC PO Box 421529 Houston, TX 77242	MFDR Tracking #: M4-10-2995-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: ""Access MediQuip, L.L.C. is filing a medical dispute for the recent denial on the above-referenced claim. Texas Mutual Insurance Company had only approved and paid on one HCPCS code L8680 and denied all other billed HCPCS for other required components of the stimulator. Per the EOB the claim was paid for 1 units/electrodes and there were 16 units/electrodes billed. We are requesting you reimburse the remaining 15 units/electrodes per the fee guidelines and HCPCS description of the L8680. Also attached is the description of the Neurostimulation and information on the specification and features of the Rechargeable Implantable Neurostimulator System that clearly define {sic} of 16 electrodes required. Also, find attached per the above, the HCFA for billed charges $13,749.00 EOB audit date of 12/26/2008, and our itemized statement per item description of our billed charges. In addition, the miscellaneous supplies/equipment billed under L9900 was integral to the spinal cord stimulation system; however, separate costs were incurred; therefore, please review the claim above for payment. Please reconsider this claim and provide prompt payment according to State of Texas WCI Fee Schedule; cost of the device + 125% [Please refer to the State of Texas WCI Reimbursement Rate Guidelines regarding cost]. We anticipate the following documentation will allow you to reassess your position and provide additional payment within 30 days".

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $7,931.50

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: ""The requestor provided implantable neurostimulator electrodes and equipment to the claimant 9/10/08. Texas Mutual reimbursed the requestor for this on 11/6/08. The requestor requested reconsideration of the initial reduction of payment on 12/8/08. After careful review Texas Mutual declined to issue any additional payment. The requestor on 2/23/09 {sic} requested medical fee dispute resolution through DWC MDR. DWC Rule 133.307 at (c)(1)(A) states, "Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division…Timeliness. A requestor shall timely file with the Division's MDR Section or wave the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request…A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." One year from 9/10/08 is 9/10/09. The DWC MDR date stamp on the front of the requestor's DWC-60 packet shows date 2/23/10. The number of months from 9/10/08 to 2/23/10 is greater than twelve, which would make the requestor's request noncompliant with DWC Rule 133.307 unless subparagraph B applies. Subparagraph B states, "…A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or

liability; (ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the carrier previously denied payment based on medical necessity; or (iii) the dispute relates to a refund notice issued pursuant to a Division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice. Review of Texas Mutual's claim file shows none of these exceptions apply. For this reason Texas Mutual believes no additional payment is due."

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
9/10/08	L8680	N/A	$7,980.00	$0.00
9/10/08	L9900	N/A	$949.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 11/6/2008

- CAC – 217 Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: to be used for workers' compensation only)
- CAC – 45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use group codes PR or CO depending upon liability).
- CAC – 97 The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 426 – Reimbursed to fair and reasonable.
- 793 – Reduction due to PPO contract. PPO contract was applied by Focus/Beech Street. For provider support 1-800-243-2336.
- An implantable neurostimulator electrode, each; is a single implantable electrode array (I.E., catheter, plate) that may contain multiple contacts. Within the context or an implantable neurostimulator electrode, each; regardless of the number of contacts. Only two implantable neurostimulator electrodes may be billed for a dual array pulse generator (L8687 or L8688).

Explanation of benefits dated 12/26/2008

- CAC – W4 No additional reimbursement allowed after review of appeal/reconsideration.
- CAC – 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 732 – Accurate coding is essential for reimbursement. Services are not reimbursable as billed. CPT and/or modifier billed incorrectly.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Issues

1. Did the requestor submit the medical fee dispute timely and in accordance with 28 Tex. Admin. Code §133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. The Requestor submitted a medical fee dispute for date of service 9/10/2008. The Division received the dispute on 2/23/2010.
2. Pursuant to Rule 133.307(c)(1)(A) Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.
3. The medical fee dispute was not received timely by the Division according to Rule 133.307. Therefore, the Requestor has waived their right for MDR for the disputed services.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature	Medical Fee Dispute Resolution Officer	**4/27/10**
		Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.